4/1/10 POC accepted B Lawson HFS III



Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS503S | A. BUILDING _____ B. WING _____ | 03/10/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 3/10/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.<br><br>Complaint #NV00024155 was substantiated with a deficiency cited. (See Tag Z230)<br><br>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.<br><br>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. | Z 000 | ***Public Notice and Disclaimer:***<br>*This plan of correction is signed and submitted as required under State law. The signing and submission of this plan does not constitute an admission on the part of Delmar Gardens of Green Valley ("facility") as to the accuracy of the surveyor's findings or the conclusions drawn there from. The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency or the scope and severity regarding any of the deficiencies cited is correctly applied.*<br><br>*Any changes to facility policies and procedures shall be considered to be subsequent remedial measures as that concept is applied in Rule 407 of the Federal Rules of Evidence and NRS 48.095 and shall be inadmissible in any proceeding on that basis.*<br><br>*The facility submits this plan of correction with the intention that it shall be inadmissible by any third party in any regulatory, civil or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility*<br><br>*Do to the nature of the reporting system that the Bureau of Health Care Quality and Compliance is required to utilize many of the reports that the facility voluntarily submits for review are categorized as complaints and thus are included with any actual "complaints" for review. This may mean that the number of actual complaints noted is not truly represented and is overstated.*<br><br>Plan of Correction Begins on Next Page | |
| Z230 SS=D | NAC 449.74469 Standards of Care<br><br>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. | Z230 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: March 29, 2010

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS503S | A. BUILDING _____ B. WING _____ | 03/10/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DELMAR GARDENS OF GREEN VALLEY | 100 DELMAR GARDENS DRIVE HENDERSON, NV 89014 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 1<br>This Regulation is not met as evidenced by:<br>Based on interview and record review, the facility failed to obtain an order for pain medication for multiple complaints of pain in the left hip for 1 of 5 residents (Resident #1).<br><br>Severity: 2 Scope: 1 | Z230 | **Z230 (Complaint)**<br>The facility will continue to promote the services and treatment that are necessary to attain and maintain the highest practicable physical, mental and psychosocial well being of each resident.<br><br>Resident #1: Resident no longer resides in facility.<br><br>The RN/Staff Development Coordinator and Therapy Director will re-inservice licensed nursing and therapy staff on the facility procedure for pain control which includes assessment and maintenance of pain control as well as obtaining physician orders for pain medication. Residents with complaints of pain will be documented on the 24-hour Nursing Report.<br><br>The Director of Nursing or designee will conduct random audits of nursing documentation and care as it relates to the assessment and maintenance of pain control during routine daily rounds.<br><br>The Director of Nursing will report findings to the QA Committee.<br><br>Completion date: April 1, 2010 | April 1, 2010 |